

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IN005269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/01/2015
NAME OF PROVIDER OR SUPPLIER HOOSIER UPLANDS HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 W MAIN ST MITCHELL, IN 47446		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	<p>Initial Comments</p> <p>This was a State licensure home health complaint investigation survey.</p> <p>Complaint #: IN00161146 - Unsubstantiated: Lack of sufficient evidence.</p> <p>Survey Date: 4-1-15</p> <p>Facility #: 005269</p> <p>Medicaid Vendor #: 100272810A</p> <p>Hoosier Uplands Home Health was found to be in compliance with the Indiana State rules for home health agency licensure 410 IAC 17-12-3(b)(2)(A) and 410 IAC 17-12-3(c)(1) and (2) as were related to this complaint.</p> <p>Quality Review: JE 4/2/15</p>	N 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE